

1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 JAMES M. LEDAKIS  
Supervising Deputy Attorney General  
3 ERIN M. SUNSERI, State Bar No. 207031  
Deputy Attorney General  
4 110 West "A" Street, Suite 1100  
San Diego, CA 92101  
5 San Diego, CA 92186-5266  
Telephone: (619) 645-2071  
6 Facsimile: (619) 645-2061

7 Attorneys for Complainant

8  
9 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2009-124

13 PAMELA KAY LANKFORD  
7405 Charmont Drive, Apt. 2105  
San Diego, CA 92122

**A C C U S A T I O N**

14 Registered Nurse License No. 642815

15 Respondent.  
16

17 Complainant alleges:  
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19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in  
21 her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),  
22 Department of Consumer Affairs.

23 2. On or about August 12, 2004, the Board issued Registered Nurse License  
24 Number 642815 to Pamela Kay Lankford ("Respondent"). Respondent's registered nurse  
25 license expired on August 31, 2006, and has not been renewed.

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1 (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.  
2 This section shall not apply to the possession of any controlled substance by a  
3 manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist,  
4 optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse  
practitioner, or physician assistant, when in stock in containers correctly  
labeled with the name and address of the supplier or producer.

5 Nothing in this section authorizes a certified nurse-midwife, a nurse  
6 practitioner, a physician assistant, or a naturopathic doctor, to order his or  
her own stock of dangerous drugs and devices.

7 8. Health and Safety Code section 11173, subdivision (a), states, in pertinent part:

8 No person shall obtain or attempt to obtain controlled substances, or  
9 procure or attempt to procure the administration of or prescription for controlled  
substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .

#### 10 Cost Recovery

11 9. Code section 125.3 provides, in pertinent part, that the Board may request the  
12 administrative law judge to direct a licensee found to have committed a violation or violations  
13 of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
14 enforcement of the case.

#### 15 CONTROLLED SUBSTANCES AT ISSUE

16 10. "Vicodin", a combination drug containing 5 mg hydrocodone bitartrate, also  
17 known as dihydrocodeinone, and 500 mg acetaminophen per tablet, is a Schedule III controlled  
18 substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

#### 19 FIRST CAUSE FOR DISCIPLINE

##### 20 (Diversion and Possession of Controlled Substances)

21 11. Respondent is subject to disciplinary action pursuant to Code section 2761,  
22 subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,  
23 subdivision (a), in that in or about October 2004, while employed and on duty as a  
24 registered nurse at Antelope Valley Hospital, Lancaster, California, Respondent did the  
25 following:

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1                   **Diversion of Controlled Substances:**

2                   a.       Respondent obtained the controlled substance Vicodin by fraud, deceit,  
3 misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173,  
4 subdivision (a), by removing various quantities of Vicodin from the hospital's Pyxis system<sup>1/</sup>  
5 under the names of several different patients (patient numbers 380858, 893677, 920616, and  
6 318214), when, in fact, there were no physician's orders authorizing the medication for the  
7 patients. In one instance, Respondent removed two tablets of Vicodin for a patient (patient  
8 number 644197) when, in fact, the physician's order called for the administration of only one  
9 tablet of Vicodin for the patient. Further, Respondent failed to chart the administration or  
10 wastage of the Vicodin in the medication administration records ("MAR"), or made false  
11 statements or grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's  
12 records to conceal her diversion of the controlled substance, as set forth in paragraph 12 below.

13                   **Possession of Controlled Substances:**

14                   b.       Respondent possessed unknown quantities of the controlled substance  
15 Vicodin without a valid prescription from a physician, dentist, podiatrist, optometrist,  
16 veterinarian, or naturopathic doctor, in violation of Code section 4060.

17                   **SECOND CAUSE FOR DISCIPLINE**

18                   **(False Entries in Hospital/Patient Records)**

19                   12.       Respondent is subject to disciplinary action pursuant to Code section 2761,  
20 subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,  
21 subdivision (e), in that in or about October 2004, while employed and on duty as a registered  
22 nurse at Antelope Valley Hospital, Lancaster, California, Respondent falsified, or  
23 made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other  
24 records pertaining to the controlled substance Vicodin, as follows:

25 \_\_\_\_\_  
26                   1. The Pyxis Medication System is a computerized medication administration system designed to improve  
27 communication between hospital pharmacies and clinical settings, to decrease medication errors, and to improve  
28 patient safety. Individual licensed personnel are assigned a password to access the Pyxis by the hospital or health  
care agency Pharmacy Department. The system can thus identify users, the time they log in and out of the system,  
and their activities while logged in the system, enabling the hospital or health care agency to identify medication  
discrepancies.

1                   **Patient # 893677:**

2                   a.       On October 20, 2004, at 2309 hours, Respondent withdrew 2 tablets of  
3 Vicodin from the Pyxis under the patient's name when, in fact, there was no physician's order  
4 authorizing the medication for the patient. Further, Respondent failed to chart the administration  
5 or wastage of the Vicodin on the patient's MAR and otherwise account for the disposition of the  
6 two tablets of Vicodin.

7                   b.       On October 21, 2004, at 0616 hours, Respondent withdrew 2 tablets of  
8 Vicodin from the Pyxis under the patient's name when, in fact, there was no physician's order  
9 authorizing the medication for the patient. Further, Respondent failed to chart the administration  
10 or wastage of the Vicodin on the patient's MAR and otherwise account for the disposition of the  
11 two tablets of Vicodin.

12                   **Patient # 644197:**

13                  c.       On October 23, 2004, at 0522 hours, Respondent withdrew 2 tablets of  
14 Vicodin from the Pyxis under the patient's name when, in fact, the physician's order called for  
15 the administration of only one tablet of Vicodin for the patient. Further, Respondent charted on  
16 the patient's MAR that she administered two tablets of Vicodin to the patient at 0518 hours.

17                   **Patient # 318214:**

18                  d.       On October 26, 2004, at 1947 hours, Respondent withdrew 2 tablets of  
19 Vicodin from the Pyxis under the patient's name when, in fact, there was no physician's order  
20 authorizing the medication for the patient. Further, Respondent failed to chart the administration  
21 or wastage of the Vicodin on the patient's MAR and otherwise account for the disposition of the  
22 two tablets of Vicodin.

23                   **Patient # 380858:**

24                  e.       On October 27, 2004, at 0054 hours, Respondent withdrew 2 tablets of  
25 Vicodin from the Pyxis under the patient's name when, in fact, there was no physician's order  
26 authorizing the medication for the patient. Further, Respondent failed to chart the administration  
27 or wastage of the Vicodin on the patient's MAR and otherwise account for the disposition of the  
28 two tablets of Vicodin.

**Patient # 920616:**

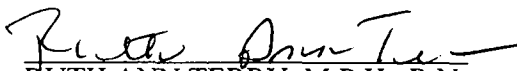
f. On October 27, 2004, at 0428 hours, Respondent withdrew 2 tablets of Vicodin from the Pyxis under the patient's name when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Vicodin on the patient's MAR and otherwise account for the disposition of the two tablets of Vicodin.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 642815, issued to Pamela Kay Lankford;
2. Ordering Pamela Kay Lankford to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: 11/26/08.

  
RUTH ANN TERRY, M.P.H., R.N.  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant